

Complete Summary

GUIDELINE TITLE

Beyond Munchausen Syndrome by proxy: identification and treatment of child abuse in a medical setting.

BIBLIOGRAPHIC SOURCE(S)

Stirling J Jr, American Academy of Pediatrics Committee on Child Abuse and Neglect. Beyond Munchausen syndrome by proxy: identification and treatment of child abuse in a medical setting. Pediatrics 2007 May;119(5):1026-30. [17 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

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COMPLETE SUMMARY CONTENT

SCOPE
 METHODOLOGY - including Rating Scheme and Cost Analysis
 RECOMMENDATIONS
 EVIDENCE SUPPORTING THE RECOMMENDATIONS
 BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
 QUALIFYING STATEMENTS
 IMPLEMENTATION OF THE GUIDELINE
 INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
 CATEGORIES
 IDENTIFYING INFORMATION AND AVAILABILITY
 DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Munchausen syndrome by proxy

GUIDELINE CATEGORY

Diagnosis
 Evaluation

Management
Treatment

CLINICAL SPECIALTY

Family Practice
Pediatrics

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To help the physician recognize Munchausen syndrome by proxy and determine when to report a case to their state's child protective service agency

TARGET POPULATION

Children who are abused by parents in a medical setting

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

1. Evaluation of medical record
2. Multidisciplinary input
3. Covert videotape surveillance

Management/Treatment

1. Informing state child protective services
2. Individual and/or family therapy
3. Monitoring ongoing medical care usage
4. Admission of child to inpatient hospital setting or partial hospital program
5. Obtain dependency to control overuse of medical resources
6. Permanent placement of child in another family setting
7. Prosecution of the offending parent
8. Consultation with pediatrician with experience/expertise in child abuse
9. Review of all medical records and involvement of all treating physicians
10. Working with multidisciplinary child protection team
11. Involvement of state social service agency
12. Involvement of whole family in treatment

MAJOR OUTCOMES CONSIDERED

- Incidence of child abuse in the medical setting
- Reporting of child abuse in the medical setting

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnosis

Child abuse is not a diagnosis of exclusion. On the contrary, when a clinician suspects that a disease has been falsified, this hypothesis must be pursued vigorously and the diagnosis must be confirmed if the child is to be spared further harm. In seeking to determine if signs and symptoms of a disease have been fabricated, the physician should make every effort to gather information from all those involved and make other professionals aware of the concerns. Care of children who are victims of factitious disorder by proxy often involves a variety of medical personnel, from primary care physicians and medical subspecialty consultants to dietitians, physical therapists, and social service workers, and each has a unique perspective. Nursing and support staff can frequently contribute to making the correct diagnosis by reporting their observations of, and experiences with, the child and family to the supervising physician. It should be stressed, however, that the falsification of a medical condition is a medical diagnosis. Although multidisciplinary input can be very helpful in diagnosis and essential in treatment, psychologists, social workers, and others are not in a position to make or confirm this diagnosis.

When it is suspected that no true disease exists and it is felt that harm to the child is imminent, the use of covert videotape surveillance has been recommended. Such surveillance may capture a parent's misbehavior, as when a child is being physically abused in the hospital. It may fail to confirm reported symptoms when they are being exaggerated or exonerate a suspected caregiver when a disease truly exists. In any event, video surveillance cannot be considered a gold standard or held as the only way of diagnosing this insidious form of child abuse. When videotaping is used, adequate safeguards such as continuous surveillance and a well-understood plan of action must be present to prevent further injury.

Treatment

When considering treatment for child abuse taking place in a medical setting, the basic principles used in any other type of child abuse case should be applied:

1. Make sure the child is safe.
2. Make sure the child's future safety is also assured.
3. Allow treatment to occur in the least restrictive setting possible.

If the parent's care-seeking is harming the child but the parent refuses to cooperate with the physician in limiting the amount of medical care to an appropriate level, the state child protective services agency should be informed. If the parent persists in harming the child, medical child abuse should be reported in the same way as physical and sexual child abuse. Any time that a dependent child

is being hurt by an adult's action, child protective services should become involved.

A list of possible interventions follows, from the least restrictive to the most restrictive. Some of these options require action by outside agencies (child protective services, private counselors, law enforcement, etc).

1. Use individual and/or family therapy while depending on a primary care physician to be "gatekeeper" for future medical care utilization.
2. Monitor ongoing medical care usage by involving people or institutions outside the medical practice to alert the physician gatekeeper about health care issues. For example, in the event of a child protective services investigation, or with the parent's consent, the insurance provider can be alerted to inform the primary care physician or medical home about visits to other professionals. Another example would be having the parent authorize the school to call the physician any time the child is absent or have school officials agree not to excuse any absence without the physician's approval.
3. Admit the child to an inpatient hospital setting or a partial hospital program, where his or her actual signs and symptoms can be monitored (as opposed to the signs and symptoms reported by the parent). This admission is a very important resource if the parent tends to exaggerate or lie about the child's pain or disability. A program that treats the whole family can then work to define the child as normal in the parents' eyes.
4. Involve child protective services to obtain dependency, either in or out of the home, to control overuse of medical resources and gradually reintroduce the child to the caregiver's home while monitoring the child's safety.
5. Place the child in another family setting permanently.
6. Prosecute the offending parent and incarcerate him or her, thus eliminating access to the child.

The physician's role in options 4 through 6 would be to report the case to the appropriate authorities, carefully document the abuse, and, if needed, testify on the child's behalf in courts of law. Obviously, options 3 through 6 will be required only in the most extreme or persistent cases of medical abuse.

Clinical Advice

When physicians diagnose and manage cases of child abuse in the medical setting, the following clinical advice will help ensure a more successful outcome of the case:

1. Whenever possible, have a pediatrician with experience and expertise in child abuse consult on the case, if not lead the team. This may help to reduce "false-positive" misdiagnosis and better identify actual cases.
2. Review all the medical charts pertinent to these complicated cases. Abusing parents often seek medical care from a variety of sources and may change physicians frequently. It is important to involve all the treating physicians in the process. Primary care and subspecialty physicians should work together to identify parents who seek excessive medical care. They should communicate regularly about the degree of medical care utilization and reach consensus on management. Cooperation of all the involved physicians is not only critical to

- good patient care, but it can also keep the parent from becoming confused or deliberately playing one doctor against another.
3. Work with a hospital- or community-based multidisciplinary child protection team. Such teams bring a variety of skills and viewpoints to the treatment process and provide expert consultation for the primary care physician in child maltreatment and child protection.
 4. When a "more restrictive" response is needed, do not hesitate to involve the state social service agency responsible for protecting children from abuse. If the physician has access to a multidisciplinary child protection team, the team can help coordinate efforts to protect the child and facilitate communication with the state child protection agency.
 5. Involve the whole family in the treatment. Their entire view of illness and health in their lives has to be adjusted. Ongoing family issues must be addressed to guarantee the future safety of the victim and any other children in the home. Therapists may use effective behavioral management techniques to change the child's dysfunctional behaviors, when appropriate.

Summary

What has been known as Munchausen syndrome by proxy may be better described as pediatric condition falsification or simply child abuse that occurs in a medical setting. In aggressively seeking an elusive diagnosis, physicians can sometimes cause harm to their patient and must remain aware of this possibility. The pediatrician who suspects that signs or symptoms of a disease are in fact being fabricated should concentrate on the harm or potential harm to the child caused by the actions of that caregiver and the efforts of the medical personnel to diagnose and treat a nonexistent disease. Proper diagnosis of fabricated disease involves thorough evaluation of medical charts, clear communication among medical professionals, and, often, a multidisciplinary approach. A focus on the motives of the caregiver, although useful in therapy, is unnecessary for the diagnosis of this form of child abuse.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate and timely diagnosis of children who are suspected victims of abuse in the medical setting can ensure appropriate evaluation and investigation, and can lead to prevention of further abuse, appropriate treatment, and future protection and safety of the child

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 May

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics

GUIDELINE COMMITTEE

Committee on Child Abuse and Neglect

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Academy of Pediatrics \(AAP\) Policy Web site](#).

Print copies: Available from American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on August 31, 2007. The information was verified by the guideline developer on September 18, 2007.

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